EXPANDING FINANCIAL ELIGIBILITY FOR THE MENTAL HEALTH SERVICES PLAN AND COST SHARING OPTIONS

Prepared for the

HJR 35 Subcommittee

by

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INTRODUCTION

The HJR 35 study subcommittee at its June meeting requested information on the cost to expand financial eligibility for the Mental Health Services Plan (MHSP) and potential cost sharing options that could also be considered. After that request was made, changes to financial eligibility were announced that will impact the cost of increasing MHSP financial eligibility.

SUMMARY

Expanding financial eligibility above 150 percent of the federal poverty level for MHSP first requires funding two distinct pieces: 1) the cost to fund the two most significant changes in eligibility proposed by the Department of Public Health and Human Services (DPHHS) as part of its supplemental appropriation of $4 million general fund in fiscal 2000; and 2) the cost to expand eligibility above 150 percent of the poverty level. The cost to reinstate recently announced eligibility changes is estimated to be $9.9 million over the 2003 biennium and the cost to expand eligibility from 150 to 200 percent of the federal poverty level is estimated to add another $3.5 million.

Both cost estimates: 1) include increases in the number of persons who would become eligible for the program; 2) include inflation for prescription drugs; and 3) are based on preliminary cost data for MHSP. The cost to expand eligibility to 200 percent of poverty is highly dependent on assumptions of the number of persons who would become eligible for the program and the number of those eligible who receive services.

The general fund cost to increase financial eligibility for MHSP could be partially offset through cost sharing mechanisms such as copayments or premiums or use of federal funds, such as matching funds from the Children's Health Insurance Program (CHIP). The amount of cost offset depends on the type and level of cost sharing selected. Options presented for subcommittee review include: 1) copayments; 2) capped copayment amounts; 3) premium payments; 4) a sliding fee scale for premiums based on income levels; and 5) application fees.

MENTAL HEALTH SERVICES PLAN

MHSP is a fee-for-service, state funded program that provides mental health services and prescription drugs for adults who have a serious and disabling mental illness (SDMI) and children who are seriously emotionally disturbed (SED). Persons who meet the clinical eligibility must also meet financial eligibility criteria. Unlike eligibility for the Medicaid program, there are no assets or resources tests for MHSP. But like the Medicaid program, once someone meets programmatic eligibility they may receive MHSP services.

MHSP is the evolutionary child of the Mental Health Access Plan (MHAP), established when the statewide mental health managed care contract was implemented April 1997. Prior to that time general fund supporting community mental health services had been

used to fund contracts with community mental health centers (CMHCs), which provided services to indigent persons. CMHCs also provided services to other persons and most centers charged fees based on a sliding fee scale related to income.[1]

MHAP had the same clinical eligibility as MHSP and financial eligibility was initially established at 200 percent of the poverty level. MHAP financial eligibility was reduced to 150 percent of the federal poverty level in March 1999 because of the losses sustained by the managed care contractor. Financial eligibility remained at that level after the state assumed the management of and financial risk for the program. However due to recent general fund cost over runs and statutory requirements,DPHHS published a plan to reduce MHSP financial eligibility to 120 percent of the federal poverty level. Table 1 shows the federal poverty level by family size and incomes at various percentages of poverty.

TABLE 1
2000 Federal Poverty Index for Various Levels of Poverty by Family Size

Family Size	<----------Poverty Level----------> 100%	120%	150%	180%	200%
1	$8,350	$10,020	$12,525	$15,030	$16,700
2	11,250	13,500	16,875	20,250	22,500
3	14,150	16,980	21,225	25,470	28,300
4	17,050	20,460	25,575	30,690	34,100
5	19,950	23,940	29,925	35,910	39,900
6	22,850	27,420	34,275	41,130	45,700
7	25,750	30,900	38,625	46,350	51,500
Each Additional Person	$2,900	$3,480	$4,350	$5,220	$5,800

Statutory Authority for Mental Health Services Plan

Section 53-6-131(10)[2], MCA establishes financial eligibility for MHSP at no greater than 200 percent of the federal poverty level[3]. However, the effective financial eligibility could exceed 200 percent of poverty because the same statute also allows DPHHS in rule to specify under what circumstances deductions for medical expenses should be used to

[1] CMHCs continue to provide services to indigent persons and other persons needing mental health services.
[2] Appendix A shows this section of statute.
[3] The federal poverty level is updated annually and historically has increased between 1 to 5 percent annually.

reduce countable family income in determining eligibility. DPHHS is also granted the authority to establish a lower level of financial eligibility by that section of statute.

DPHHS has authority to adopt rules establishing fees, premiums, or copayments to be charged recipients for services. The fees, premiums, or copayments may vary according to family income. DPHHS cannot impose a copayment, premium or fee without adopting a rule to do so.

Mental Health Services Plan Copayments

MHSP includes copayments on prescription drugs. Copayments range from a low of the actual cost of a prescription or $5, which ever is less, to a potential high of $25. A copayment of $15 is charged on prescriptions for brand name drugs when there is a generic drug available. DPHHS can charge up to $25 on prescriptions for drugs from manufacturers who do not participate in a drug rebate program, similar to the rebate program for Medicaid.[4]

DPHHS has not yet imposed a copayment on drugs from manufacturers that do not participate in the rebate program. The Governor recently sent a letter to pharmaceutical companies requesting their participation. Prior to the Governor's letter only 1 company had signed the rebate agreement and subsequently participation increased to 47 companies as of July 21. DPHHS will implement a copayment on drugs provided by non-participating manufacturers, and give at least a 10-day notice prior to implementation.[5]

Changes to Mental Health Services Plan

DPHHS recently received a supplemental appropriation to move $4 million general fund from fiscal 2001 to fiscal 2000 to cover projected shortfalls in mental health services.[6] As required by statute (section 17-7-301, MCA)[7] DPHHS submitted a plan to reduce expenditures in the second year of the biennium by $8 million general fund (see Table 2). Several elements of the plan change MHSP eligibility and copayment amounts.

[4] Co-payments are recorded as a rebate in the accounting system. When prescription rebates are received they are recorded in a way that reduces/offsets costs. In response to a legislative audit finding, DPHHS will request in its 2003 biennium budget request that rebates be recorded in the accounting system and the expenditures previously offset by a rebate be appropriated for in the general appropriations act.

[5] Dan Anderson, Administrator, Addictive and Mental Disorders Division, DPHHS, personal conversation, July 21, 2000.

[6] For more information about the potential impacts of the mental health services budget reduction plan, see the Legislative Fiscal Division staff report published July 10, 2000.

[7] Appendix A contains statutes governing supplemental appropriations.

Table 2
Mental Health Budget Reduction Plan - 2001 Biennium

Cost Reduction	Estimated Savings	Percent of Total	Eligibles Affected
Suspend MHSP Eligibility Through Fiscal 2001 Effective August 1, 2000	$ 2,100,000	26%	1,400
Reduce MHSP Financial Eligibility to 120% of Poverty Effective September 1, 2000	2,000,000	25%	725
MSH Contractor Delay Penalty	1,070,000	13%	None
Stricter Utilization Management	1,000,000	12%	Unknown
Partial Hospitalization Rate Decrease/Site Must be at Inpatient Hospital Site	637,500	8%	Unknown
Require SDMI and SED Medical Necessity to Receive Medicaid Funded Mental Health Therapy	400,000	5%	Unknown
Move 25 MSH Patients to PACT	250,000	3%	25
Forego Fiscal 2001 Provider Rate Increase	250,000	3%	Unknown
Cancel Frontier Rate Increase	210,000	3%	Unknown
Additional Consumer Copay for Counseling Services	100,000	1%	All
Total	$ 8,017,500	100%	

The two most significant elements of the plan account for just over half of the reduction: 1) lowering MHSP financial eligibility from 150 to 120 percent of the federal poverty level effective September 1, 2000[8]; and 2) suspending new or re-enrollment in MHSP through fiscal 2001 beginning August 1, 2000. DPHHS staff testified before the Legislative Finance Committee on July 11 that the Governor had not made final decisions on implementation of the plan. However, if DPHHS wishes to give at least 10 days notice of changes to eligibility, it would have needed to make such announcements on July 21 if it were going to suspend eligibility August 1. In addition, it would need to amend administrative rules to make some of the changes contemplated in the plan.[9]

[8] Table 1 compares 120 and 150 percent of the federal poverty level by family size.

[9] DPHHS must amend administrative rules to implement changes to services subject to copayments. DPHHS could implement an emergency rule that is effective the day it is filed. Emergency rules are effective for 120 days, so DPHHS would also need to follow the regular rule making process to make changes permanent.

COST TO INCREASE MHSP ELIGIBILITY ABOVE 150 PERCENT OF POVERTY

The cost to increase MHSP eligibility above 150 percent of the federal poverty level includes two components: 1) the cost to reinstate eligibility from 120 to 150 percent of poverty and reinstate enrollment in MHSP; and 2) the additional cost to raise eligibility above 150 percent of the poverty. Table 3 shows the estimated general fund cost for the 2003 biennium for each of these components.

Table 3
General Fund Cost to Expand MHSP Eligibility Above 150% of the Federal Poverty Level

Financial Eligibility Increase	General Fund Annual	General Fund Biennial	General Fund Annual	General Fund Biennial
Reinstate Financial Eligibility to 150% of Poverty*				
Raise Eligibility from 120% to 150%*	$ 2,092,684	$ 4,293,013	$2,092,684	$ 4,293,013
Allow New or Re-enrollment in MHSP**	2,767,743	5,593,094	2,767,743	5,593,094
Subtotal to Reinstate Eligibility to 150% of Poverty	$ 4,860,427	$ 9,886,107	$4,860,427	$ 9,886,107
Raise Financial Eligibility to 180% or 200% of Poverty	180% of Poverty		200% of Poverty	
Estimated Number of New Eligibles***	434		621	
Estimated Number of New Recipients****	246		351	
Annual Cost per Recipient*****	$ 4,961		$ 4,961	
Subtotal to Raise Eligibility	$ 1,217,847	$ 2,461,042	$1,739,781	$ 3,515,774
Total Cost to Reinstate and Raise Financial Eligibility	$ 6,078,274	$12,347,149	$6,600,208	$13,401,881
Value of Pharmacy Rebates		$ 346,708		$ 376,325

Notes
*Costs are based on LFD estimates of the cost to fund 745 eligible persons at an annual average cost of $2,810 in fiscal 2000 and 767 eligible persons at an average annual cost of $2,869 in fiscal 2003. These cost estimate are lower than DPHHS estimates of the annual average cost of services for persons eligible for MHSP.
**Costs are based on DPHHS estimates in the mental health services reduction plan. Costs are annualized for full year implementation since eligibility reductions are implemented after the start of the state fiscal year.
***The estimated number of new eligibles for raising eligibility to 200% of poverty is based on the number of persons estimated to have lost eligibility when eligibility was initially reduced from 200% to 150% of poverty and increased 3% per year, about the average annual increase in the poverty level index over the last several years. The number of eligibles for 180% of poverty is estimated to be 70% of the number of persons eligible at 200% of poverty.
****The number of new recipients is based on the average of 56% of new eligibles, which is the average number of persons receiving services compared to the number of persons eligible for MHSP through February 2000.
*****The cost per recipient listed is the FY2002 cost. The biennial cost includes 10% annual inflation on the cost of prescriptions compounded beginning in the FY2000 base year, through the end of the 2003 biennium.

The estimated costs range from $9.9 million to reinstate financial eligibility to 150 percent of poverty and allow new or re-enrollment in MHSP, to a high of $13.4 million to reinstate and further raise financial eligibility to 200 percent of the federal poverty level.

The cost estimates shown in Table 3 should be reviewed with a number of caveats in mind. First, estimates are based on incomplete data. Since MHSP was initiated just about one year ago, there is no historic data with which to estimate costs.[10] Paid claims data recorded as of June 30, the close of fiscal year 2000, seems to be fairly complete through April. As additional data becomes available the cost estimates of expanding MHSP eligibility can be refined.

Table 3 estimates of reinstatement for MHSP eligibility reductions are based on annualized costs, while the DPHHS cost savings published in the mental health services budget reduction plan (see Appendix B) are effective for 10 to 11 months of fiscal 2001. Table 3 estimates also include increases for inflation in the cost of prescription drugs.

Table 3 does not include the general fund cost offsets included in the mental health services budget reduction plan, such as increased savings due to enhanced utilization review or increased consumer copayments, because such savings: 1) are offset by other items in the plan that increase costs (new PACT programs); or 2) won't be continued (contractor penalty assessments).

Table 3 estimates that pharmacy rebates would total 13.5 percent of pharmacy costs, based on DPHHS estimates, or about $400,000 over the 2003 biennium for either of the options to reinstate and increase eligibility. Pharmacy rebates will be deposited to the general fund as income, so they are not shown as a cost offset.

The average annual cost per recipient in Table 3 is based on the average annual cost of MHSP services through April 2000, including 10 percent annualized inflation in the cost of prescription drugs. The cost of prescription drugs is estimated to be 20.8 percent of the total cost of MHSP services, which is the average through April 2000. Legislative Fiscal Division (LFD) staff requested that WEFA, an economic consulting service, prepare specific information on inflation of drugs used to treat mental illness. WEFA data indicates that general inflation for all drugs was 5.3 percent from calendar 1999 to 2000. However, from July 1999 through April 2000, the average cost per MHSP prescription service increased from $71 to $79, or 11.3 percent.

Table 3 anticipates that all additional MHSP costs would be funded from the general fund, which could overstate general fund costs depending on how federal CHIP funds are used. DPHHS is reviewing fiscal 2000 MHSP expenditures and funding to assure that CHIP funds were used as a prior resource for all services eligible for CHIP funding that were provided to children eligible for both CHIP and MHSP.[11] As discussed in several LFD staff reports, depending on how much CHIP grant funds remain and whether or not the executive branch decides to request expansion of CHIP financial eligibility, there

[10] DPHHS staff have indicated that cost data from the former managed care contractor is not useful in estimating costs for MHSP.

[11] CHIP and MHSP have similar financial eligibility criteria. The primary reasons that MHSP children would not be eligible for CHIP would be that their parents are state employees or the family has some type of health insurance. According to Randy Poulsen, Chief, Mental Health Services Bureau, Addictive and Mental Disorders Division, DPHHS, there were 961 children eligible for MHSP and 631of those children (about 2/3) were not enrolled in CHIP as of July 5, 2000.

could be federal CHIP funds available to match up to 80 percent of MHSP costs for children eligible for both programs. Both of these uses of CHIP federal funds could lower the general fund cost of 2003 biennium MHSP services.

The final caveat regarding cost estimates in Table 3 is that DPHHS has had insufficient time to review and comment on the estimates. Cost estimates might change depending on DPHHS comments and input. For instance, DPHHS, in its preliminary budget request, estimated that the cost to increase eligibility to 200 percent of the federal poverty level would be about $4 million general fund or $0.5 million higher than the LFD estimate. The main differences between the estimates are that DPHHS included: 1) an additional 5 percent consumer copayment on services; 2) a 15 percent annual rate of inflation for prescription drugs; and 3) a 3 percent annual rate of inflation in the cost of community services. The combined effect results in an annual average cost per recipient of about $6,300 compared to the LFD estimate of about $5,000.

Magnitude of Differences in Reinstating Eligibility Compared to Increasing Eligibility

The biennial cost estimates to reinstate financial eligibility from 120 to 150 percent of the federal poverty level do not intuitively compare to the estimated cost to increase eligibility from 150 to 200 percent. Some of the difference can be explained in that there are more persons estimated to be eligible for services in the 120 to 150 percent income range than the 150 to 200 percent range.

Additionally, LFD staff cost estimates of changing eligibility from 150 to 120 percent of poverty are less than those of DPHHS. LFD staff are unable to thoroughly explain the total cost differences between DPHHS and LFD estimates. Part of the reason is that LFD staff derived a lower average annual cost of services for persons eligible for MHSP. Joint DPHHS and LFD review of data and clarification of respective assumptions might clarify further differences between the estimates and enhance the accuracy of cost estimates.

COST SHARING OPTIONS FOR MHSP

There are several types of cost sharing options used in public and private health insurance plans. There are two general categories used in fee-for-service type plans: 1) premiums; and 2) copayments. Usually health insurance programs include some sort of stop loss provisions on participants' costs and public plans may consider income levels in assessing cost sharing options.

This report will focus on cost sharing for persons eligible for MHSP but not Medicaid since federal regulations impact the level of copayments that Medicaid eligible persons can be charged. CHIP will be discussed in relation to: 1) its current cost sharing structure; and 2) potential cost sharing structure if CHIP funding were to match additional MHSP services.

Premiums

Use of premiums is more common in private health insurance plans than in publicly funded programs. However, the recently enacted federal Ticket to Work Improvement and Work Incentive Act allows states to expand Medicaid coverage to disabled, working persons with incomes in excess of current financial eligibility standards and charge premiums to help cover the cost. Currently some persons eligible in the medically needy category for Medicaid pay the spend-down or incurment much like an insurance premium. They have the option to make a monthly cash payment to DPHHS equal to their monthly incurment and are then eligible for Medicaid for the remainder of the month.

Copayments

DPHHS funded mental health services programs include copayments and the amounts and types of services to which the copayment applies vary depending on a person's eligibility.[12] Copayments can be established as a: 1) certain percent of the charge allowed by an insurance plan[13]; or 2) a fixed amount by service.

Most insurance plans, especially publicly funded programs, establish an upper payment limit for different types of service. Insurance plans try to establish provider networks that accept the upper payment limit as payment in full, even if billed charges exceed the upper payment limit. In such plans, copayments established as a fixed percent of costs would be the cost to the health plan participant. However, if out-of-network health care providers do not accept the upper payment limit, the insured would be responsible for the copayment and balance owed above allowed charges.

Sometimes copayments are established as a fixed amount by service. For instance, managed care plans may charge a fixed fee for doctor office visits or a hospital stay. MHSP includes a fixed copayment for prescription drugs and the mental health services budget reduction plan includes a $5 copayment for outpatient therapy services.

Sliding Fee Scale

Sometimes publicly funded programs take ability to pay into account in establishing cost sharing mechanisms. Use of a sliding fee scale allows financial participation in a public program to be progressive - the higher a person's income, the higher the proportion of costs a person is expected to pay. Sliding fee scales can be used for copayments or premiums.

The statewide mental health managed care plan that operated from April 1997 to April 1999 included copayments based on a sliding fee scale that capped monthly amounts paid

[12] For more information on copayment amounts for different funding sources for state funded mental health services see the LFD staff report "A Thumbnail Sketch of State Funding for Public Mental Health Services and Eligibility for and Access to Services" published in January 2000.

[13] It is very rare that insurance plans will accept and pay billed charges, so the type of copayment established as fixed percent of the cost of a service will not be discussed.

by eligible persons based on income. However, the copayment plan was never implemented, because the managed care contractor did not have a payment system, nor could it find an automated product, that accommodated the monthly tracking required by the system design.

Capping Participants' Contributions

An insurance plan can cap the amount of copayments that an insured makes. A cap can ensure that medical costs for participants do not exceed a certain thresh hold. It may be calculated over a specific length of time.

Copayments are capped at $200 per year for persons eligible for Medicaid and at $215 per year for families with incomes above 100 percent of the federal poverty level whose children are eligible for CHIP. MHSP does not cap copayments.

Application Fee

Finally, DPHHS could charge an application fee for the program. The CHIP program initially required a $15 application fee for families with incomes above 100 percent of the federal poverty level, but it was dropped June 1 because it was administratively burdensome and it was a barrier to enrollment. At the same time the application fee was dropped, the annual copayment amount for families with incomes above 100 percent of poverty level was increased from $200 to $215.

Pros and Cons

There are advantages and disadvantages of imposing cost sharing in public health programs. The most obvious advantage in the legislative appropriations process is the general fund cost offset provided by cost sharing. Other advantages can include ensuring responsible choices by participants in accessing health services since they have a financial interest in the decision and, in some cases, cost sharing can better prepare participants to live independently of public programs.

The most obvious disadvantage is the potential barrier of access to services if eligibility for the program or receipt of the service is based on a payment by the participant. However, if access to services is not denied due to lack of payment, but cost sharing is required, cost sharing can result in lower reimbursement for providers or can contribute to a provider's decision to not participate in the program. And if an eligible person is not able to consistently make rational decisions for themselves, cost sharing may discourage them from seeking needed medical care.

Finally, participation in state funded health services programs is nearly always based on financial eligibility, so participants have little or limited financial resources. The decision to impose cost sharing must take into account competing costs and needs. Cost sharing must generate sufficient revenue to be worth the price and management effort to implement the system controls and accountability to implement the plan, while not imposing barriers to access for services.

Potential General Fund Offset from Cost Sharing

Table 4 shows estimates of various cost sharing options for MHSP. The estimates do not constitute recommendations or endorsements by LFD staff. The estimates are presented to facilitate subcommittee discussion and to illustrate the effect of various options on the value of cost sharing. Examples include application of cost sharing to the lowest income groups even though: 1) it may be unrealistic to assume that all low-income persons have income to pay a share of mental health services costs; and 2) even though other programs, such as CHIP, require no cost sharing for persons with incomes below 100 percent of the federal poverty level.

Estimates are based on percentages or amounts that can be easily multiplied to determine potential values of higher rates of cost sharing. The illustrations include:

- 1 and 5 percent copayment on all services for all recipients;
- A 5 percent copayment on all services capped at $100 annually;
- A 5 percent copayment on all services capped at $100 annually, but paid only by MHSP recipients with incomes above 100 percent of the federal poverty level;
- 1 and 5 percent copayments on all services except prescription drugs;
- Annual premiums of $100 for each recipient;
- Annual premiums of $100 for each recipient with income above 100 percent of the federal poverty level;
- Annual premiums based on a sliding fee scale; and
- A $5 application fee for all eligible persons.

Table 4
Estimated Value of Cost Sharing Options for Mental Health Services Plan

Cost of Services/Type of Option	Financial Eligibility 120%	150%	180%	200%
2003 Biennium MHSP Cost	$ 22,676,296	$ 32,562,403	$ 35,023,445	$ 38,539,218
Copayment				
1% on All Services	$ 226,763	$ 325,624	$ 350,234	$ 385,392
5% on All Services	1,133,815	1,628,120	1,751,172	1,926,961
Capped at $100 per Recipient Annually**	386,240	444,080	478,837	493,734
Capped at $100 for Recipients Above 100% of Poverty	61,520	119,280	138,920	147,337
1% on All Services Except Pharmacy	$ 174,880	$ 251,121	$ 270,101	$ 297,214
5% on All Services Except Pharmacy	874,398	1,255,606	1,350,504	1,486,072
Premium				
$100 on All Recipients Annually	$ 482,900	$ 555,100	$ 579,650	$ 590,171
$100 on All Recipients Above 100% of Poverty	61,520	119,280	138,920	147,337
Premium Based on Sliding Fee Scale - 0 to 2% of Median Income for Family of 1				
Recipients with Incomes 0 to 50% of Poverty - 0.5%	$ 10,196	$ 10,196	$ 10,196	$ 10,196
Incomes 51 to 80% of Poverty - 0.75%	20,009	20,009	20,009	20,009
Incomes 80 to 100% of Poverty - 1%	30,529	30,529	30,529	30,529
Incomes 101 to 120% of Poverty - 1.25%	72,559	72,559	72,559	72,559
Incomes 121 to 150% of Poverty - 1.5%		68,976	68,976	68,976
Incomes 151 to 180% of Poverty - 1.75%			59,192	59,192
Incomes 181 to 200% of Poverty - 2%				111,270
Annual Total Sliding Fee Scale	$ 133,293	$ 202,269	$ 261,460	$ 372,731
Biennial Total Sliding Fee Scale	$ 266,586	$ 404,538	$ 522,921	$ 745,461
Application Fee of $5 Per Annual Application	$ 26,959	$ 30,569	$ 32,741	$ 33,672

Notes:

*The MHSP base budget is assumed to be the fiscal 2000 general fund allocated by DPHHS - $11,338,148 - doubled to reflect a biennial base budget figure. The base budget does not include an estimated supplemental appropriation of $1,962,734 million reflected in the DPHHS May budget status report.

**This estimate may overstate cost sharing revenue because it assumes all persons incur equal amounts of copayments.

Cost sharing options are estimated for several ranges of MHSP financial eligibility: 120, 150, 180, and 200 percent of the federal poverty level. Those ranges were selected because information is available on the number of persons eligible for services in each of those income ranges (see Table 5).

Table 5
Income and Age Distribution of Persons Eligible for MHSP as of July 6, 2000

Income as % of Federal Poverty	Children	Adults	Total	Percent of Total
0-50%	155	1,574	1,729	36.8%
51-80%	158	596	754	16.1%
81-100%	185	534	719	15.3%
101-120%	242	527	769	16.4%
121-150%	220	502	722	15.4%
Above 150%	1	-	1	0.0%
Total	961	3,733	4,694	
Percent of Total	20.5%	79.5%		

The number of persons eligible for MHSP services by income level was run July 6, 2000. Adults comprise the majority (80 percent) of persons eligible for services. Children (defined as persons under the age of 18) are about 1/5 of the total number eligible for services.

Over 1/3 of the persons eligible for MHSP live in households with incomes below 50 percent of the federal poverty level. About 68 percent of MHSP eligible persons have incomes below 100 percent of the poverty level.

Limitations of Cost Sharing Option Estimates

All cost sharing estimates in Table 4 have several qualifications. As noted in the discussion of the cost of expanding MHSP financial eligibility, the estimates are based on preliminary paid claims data and will change when data becomes more complete. All cost sharing options are based on the estimated costs of expanding MHSP financial eligibility. Changes in the estimated cost of expanding eligibility will have a ripple effect on the estimate of cost sharing options.

At this time, data is not available to show by income level how many persons eligible for service are receiving services. If that data were available it would also change estimates of cost sharing. The estimates assume that 56.5 percent of all persons eligible for services are receiving services, which is the average penetration rate for all persons eligible for MHSP through April. That average may not be accurate for all income groups and would lower cost estimates if proportionally more persons in lower income groups are receiving services than persons in higher income groups. And if the reverse were true it would raise cost sharing estimates.

Information is not available at this time to estimate the number of families with more than one member eligible for MHSP. The estimates are based on the assumption that each eligible family includes only one MHSP eligible person. So if the subcommittee wanted to establish cost sharing options that would limit a family's cost sharing obligation, that would reduce the estimates in Table 5.

Finally, the sliding fee scale estimates are based on median incomes within poverty level brackets. The sliding fee scale raises premium payments by ¼ of 1 percent. Again, the amounts were chosen for illustrative purposes only and do not constitute a recommendation on the part of LFD staff.

Cost Sharing Estimates

A 1 percent copayment on all services paid by all persons receiving services would generate about $227,000 if financial eligibility were 120 percent of the federal poverty level to about $385,000 if financial eligibility were raised to 200 percent of poverty. A 5 percent copayment would raise 5 times that amount. However, if a 5 percent copayment were capped at $100 per recipient annually it would generate between 60 to 70 percent less revenue. If a 5 percent copayment were capped at $100 annually and required to be paid only by recipients with incomes above 100 percent of the poverty level it would raise between $61,500 to $147,000 annually.

A 1 and 5 percent copayment on all services except for pharmacy is shown for comparison purposes since the MHSP already includes a pharmacy copayment.

Cost estimates are shown for a $100 annual premium on all recipients annually and then for only those recipients with incomes above 100 percent of the federal poverty level. Cost sharing revenue falls by 88 to 84 percent when persons in lower income brackets are exempt from payment of the premium.

A sliding fee scale is shown. The increments were picked to illustrate potential revenue from premiums at different income levels and do not constitute a recommendation by LFD staff. Again, it may be unrealistic to assume persons in lower income brackets have enough disposable income to pay a premium.

Finally, the value of a $5 application fee is estimated to be about $33,000 annually if collected from all persons eligible to receive services. As noted previously, DPHHS discontinued the $15 application fee for CHIP because it was administrative burdensome and discouraged participation in the program.

CHIP Cost Sharing

CHIP includes a $215 annual copayment for families with incomes in excess of 100 percent of the federal poverty level. If CHIP funds were used to match all or more of the cost of MHSP services provided to children eligible for both programs, this analysis has not considered whether the copayment should be raised. A family with income in excess

of 100 percent of poverty with a child eligible for both CHIP and MHSP would pay the some copayments for both programs without changes. For instance, families with incomes in excess of 100 percent of poverty would pay the $215 annual CHIP copayment and copayments assessed by MHSP for all services except prescription drugs since CHIP should continue to pay for the cost of prescription drugs.

Potential Cost to Implement Cost Sharing

LFD staff have not estimated the cost or determined the system impact to implement various cost sharing options. Based on experience with MHAP, it seems that the more simple and straight forward the plan, the better. However, it is worth noting some cost sharing processes that DPHHS already administers.

The medically needy eligibility category of Medicaid requires participants to "spend down" their income on medical services to meet financial eligibility.[14] There are two ways to meet the incurment or spend down. Persons can incur medical bills and verify a spend-down in that manner or they can pay the amount of their monthly incurment to DPHHS. Monthly payments are usually selected when the incurment is small and the amount doesn't vary greatly. Once the incurment is met the persons are Medicaid eligible. Although these processes only apply to Medicaid, it is important to note that the processes are in place.

The Eligibility Screening System (TESS), which is used to establish MHSP eligibility, tracks the income level of eligible persons. So some of the basic information needed for cost sharing arrangements tied to income levels is already recorded in the system.

DIRECTION TO STAFF

The HJR 35 subcommittee may wish to direct that staff continue to refine cost analyses and present that information at the September meeting because: 1) MHSP cost data will be more complete; 2) DPHHS staff will have more opportunity to review and comment on estimates included in this report; and 3) DPHHS may have submitted its 2003 biennium budget request.

The DPHHS 2003 biennium budget has historically been submitted by the end of the first week in September. The budget submission should include several items relevant to MHSP eligibility including: 1) what level of financial eligibility will be supported within the DPHHS budget request; and 2) whether CHIP federal funds will be used to match a greater portion of MHSP costs. These decisions are material to any increases in MHSP financial eligibility that the HJR 35 subcommittee may consider. Depending on the date of the next HJR 35 subcommittee meeting, this budget information should be available for consideration. The HJR 35 subcommittee may wish to request that DPHHS

[14] Participants already meet other categorical eligibility such as dependent child(ren), aged, blind or disabled and pass resource tests. Only their income exceeds standards. It should be noted that the amount of spend down or incurment can vary and may be a substantial portion of monthly income.

specifically address both of these items at the next meeting if either or both will be requested in a bill other than the general appropriations act.

The HJR 35 subcommittee may also wish to request that LFD and DPHHS staff jointly review and refine cost estimates to increase MHSP financial eligibility that are included in this report. The HJR 35 subcommittee may also wish to select the type of cost sharing option that is most advantageous and ask that LFD and DPHHS staff evaluate the value of the option and the system, process, and management changes needed to implement the option.

APPENDIX A
SELECTED STATE STATUTES

MENTAL HEALTH SERVICES FINANCIAL ELIGIBILITY STATUTES

53-6-131 (10) The department may establish resource and income standards of eligibility for mental health services that are more liberal than the resource and income standards of eligibility for physical health services. The standards for eligibility for mental health services may provide for eligibility for households not eligible for Medicaid with family income that does not exceed 200 percent of the federal poverty threshold or that does not exceed a lesser amount determined in the discretion of the department. The department may by rule specify under what circumstances deductions for medical expenses should be used to reduce countable family income in determining eligibility. The department may also adopt rules establishing fees, premiums, or copayments to be charged recipients for services. The fees, premiums, or copayments may vary according to family income.

SUPPLEMENTAL APPROPRIATION STATUTES

17-7-301. Authorization to expend during first year of biennium from appropriation for second year -- proposed supplemental appropriation defined -- limit on second-year expenditures. (1) An agency may make expenditures during the first fiscal year of the biennium from appropriations for the second fiscal year of the biennium if authorized by the general appropriations act. An agency that is not authorized in the general appropriations act to make first-year expenditures may be granted spending authorization by the approving authority upon submission and approval of a proposed supplemental appropriation to the approving authority. The proposal submitted to the approving authority must include a plan for reducing expenditures in the second year of the biennium that allows the agency to contain expenditures within appropriations. If the approving authority finds that, due to an unforeseen and unanticipated emergency, the amount actually appropriated for the first fiscal year of the biennium with all other income will be insufficient for the operation and maintenance of the agency during the year for which the appropriation was made, the approving authority shall, after careful study and examination of the request and upon review of the recommendation for executive branch proposals by the budget director, submit the proposed supplemental appropriation to the legislative fiscal analyst.
(2) The plan for reducing expenditures required by subsection (1) is not required if the proposed supplemental appropriation is:
(a) due to an unforeseen and unanticipated emergency for fire suppression;
(b) requested by the superintendent of public instruction, in accordance with the provisions of 20-9-351, and is to complete the state's funding of guaranteed tax base aid, transportation aid, or equalization aid to elementary and secondary schools for the current biennium; or
(c) requested by the attorney general and:
(i) is to pay the costs associated with litigation in which the department of justice is

required to provide representation to the state of Montana; or
(ii) in accordance with the provisions of 7-32-2242, is to pay costs for which the department of justice is responsible for confinement of an arrested person in a detention center.
(3) Upon receipt of the recommendation of the legislative finance committee pursuant to 17-7-311, the approving authority may authorize an expenditure during the first fiscal year of the biennium to be made from the appropriation for the second fiscal year of the biennium. Except as provided in subsection (2), the approving authority shall require the agency to implement the plan for reducing expenditures in the second year of the biennium that contains agency expenditures within appropriations.
(4) The agency may expend the amount authorized by the approving authority only for the purposes specified in the authorization.
(5) The approving authority shall report to the next legislature in a special section of the budget the amounts expended as a result of all authorizations granted by the approving authority and shall request that any necessary supplemental appropriation bills be passed.
(6) As used in this part, "proposed supplemental appropriation" means an application for authorization to make expenditures during the first fiscal year of the biennium from appropriations for the second fiscal year of the biennium.
(7) (a) Except as provided in subsections (2) and (7)(b), an agency may not make expenditures in the second year of the biennium that, if carried on for the full year, will require a deficiency appropriation, commonly referred to as a "supplemental appropriation".
(b) An agency shall prepare and, to the extent feasible, implement a plan for reducing expenditures in the second year of the biennium that contains agency expenditures within appropriations. The approving authority is responsible for ensuring the implementation of the plan. If, in the second year of a biennium, mandated expenditures that are required by state or federal law will cause an agency to exceed appropriations or available funds, the agency shall reduce all nonmandated expenditures pursuant to the plan in order to reduce to the greatest extent possible the expenditures in excess of appropriations or funding. An agency may not transfer funds between fund types in order to implement a plan.

History: En. Sec. 1, Ch. 82, L. 1961; R.C.M. 1947, 79-1019; amd. Sec. 1, Ch. 11, Sp. L. January 1992; amd. Sec. 1, Ch. 357, L. 1993; amd. Sec. 17, Ch. 347, L. 1997.
Compiler's Comments:
1997 Amendment: Chapter 347 throughout section substituted references to approving authority for references to Governor; in (1), at beginning of first sentence, substituted "An agency may make" for "A state department, institution, or agency of the executive branch desiring authorization to make" and at end, after "biennium", deleted "shall submit" and inserted "if authorized by the general appropriations act", at beginning of second sentence inserted "An agency that is not authorized in the general appropriations act to make first-year expenditures may be granted spending authorization by the approving authority upon submission and approval of" and at end deleted "through the budget director", and in fourth sentence, near middle after "maintenance of the", deleted "department, institution, or" and near end, after "recommendation", inserted "for executive branch proposals"; in (4), at beginning, substituted "The agency" for "The department, institution, or agency"; and made minor changes in style. Amendment

effective July 1, 1997.
1993 Amendment: Chapter 357 inserted second sentence of (1) requiring the proposal to include a plan for reducing second-year expenditures; inserted (2) clarifying when the plan is not required; inserted second sentence of (3) requiring implementation of the plan; inserted (7) prohibiting certain supplemental appropriations; and made minor changes in style.
1992 Special Session Amendment: Chapter 11 in (1), near end of first sentence, substituted "submit a proposed supplemental appropriation" for "make application for such authorization", at end of second sentence inserted requirement of submission to Legislative Fiscal Analyst, and at beginning of third sentence inserted reference to recommendation of Legislative Finance Committee; and inserted (4) defining proposed supplemental appropriation. Amendment effective January 21, 1992.
Cross References:
Appropriation and disbursement of money from treasury, 17-8-101.
Conditions in appropriation acts, 17-8-103.

17-7-311. Proposed supplemental appropriation -- procedure. (1) A proposed supplemental appropriation and all supporting documentation must be submitted to the legislative fiscal analyst. The governor may not approve a proposed supplemental appropriation until the governor receives the legislative finance committee's written report for that proposed supplemental appropriation unless:
(a) the report is not received within 90 calendar days from the date the proposed supplemental appropriation and supporting documentation were forwarded to the legislative finance committee, in which case the governor may approve the proposed supplemental appropriation; or
(b) there has been a waiver of the review and report requirements, as provided in subsection (4).
(2) The legislative fiscal analyst shall review each proposed supplemental appropriation submitted by the governor for compliance with statutory requirements and standards and to determine the expenditures that will be reduced in order to contain spending within legislative appropriations. The legislative fiscal analyst shall present a written report of this review to the legislative finance committee. Within 10 days after the legislative finance committee's consideration of the proposed supplemental appropriation, the legislative fiscal analyst shall submit the legislative finance committee's report to the governor.
(3) Upon receipt of the legislative finance committee's written report, the governor may approve or deny the proposed supplemental appropriation or may return the proposed supplemental appropriation to the requesting agency for further information. If the governor has returned the proposed supplemental appropriation to the requesting agency and the requesting agency resubmits the proposed supplemental appropriation to the governor, all procedures provided in this section apply to the resubmitted proposed supplemental appropriation.
(4) (a) If an emergency occurs that poses a serious threat to the life, health, or safety of the public, the legislative fiscal analyst may waive the written review and the legislative finance committee's written report required by this section. After a waiver, the legislative fiscal analyst may complete the written review.

(b) Upon receipt of the waiver, the governor may approve the proposed supplemental appropriation.
(c) A waiver affects only the legislative fiscal analyst's written review and the legislative finance committee's written report on the proposed supplemental appropriation. All other proposed supplemental appropriation requirements and standards remain in effect.
(5) Nothing in this part confers on the legislative finance committee authority to approve or deny a proposed supplemental appropriation.

History: En. Sec. 2, Ch. 11, Sp. L. January 1992; amd. Sec. 2, Ch. 357, L. 1993.
Compiler's Comments:
1993 Amendment: Chapter 357 at end of first sentence of (2) inserted "and to determine the expenditures that will be reduced in order to contain spending within legislative appropriations"; and made minor changes in style.
Effective Date: Section 4, Ch. 11, Sp. L. January 1992, provided that this section is effective January 21, 1992.